Attachment 7b

MAPB-087-013-D
Date: 9/1/87

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/TA

THERAPY ATTACHMENT

(Physical- Occupational-Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
RECIPIENT	IM	A	1234567890	19

PROVIDER INFORMATION

(6) THERAPIST'S NAME AND CREDENTIALS	(7) THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) THERAPIST'S TELEPHONE NUMBER
I.M. PERFORMING, O.T.R.	12345678	(XXX) XXX-XXXX

(9) REFERRING/PRESCRIBING PHYSICIAN'S NAME: I.M. REFERRING/PRESCRIBING

A. Requesting: ☐ Physical Therapy ☒ Occupational Therapy ☐ Speech Therapy

B. Total time per day requested: 60 minutes
Total Sessions per week requested: 3 for each procedure requested.
Total number of weeks requested: 16

C. Provide a description of the recipient's diagnosis and problems and date of onset.

PRIMARY DIAGNOSIS	ICD9 CODE	DATE OF ONSET
Rheumatoid Spondylitis	720	Age 16

SECONDARY DIAGNOSIS	ICD9 CODE	DATE OF ONSET
1. Epilepsy (Major Motor)	345.1	Age 4

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D. Brief Pertinent History:

Client lived at home with family prior to last nursing home admission.
Client has completed high school and is a part-time student at XYZ University in Data Processing.

E. Therapy History

		Location	Date	Problem Treated
P.T.	ABC Hospital	Anytown, WI	1985	Spinal Involvement of Rheumatoid Spondylitis
	XYZ Nursing Home	Anytown, WI	7/1 - 8/15/86	Gait, Balance and Dependence in ADL
OT	ABC Hospital	Anytown, WI	6/1986	Balance and Transfers
	XYZ Nursing Home	Anytown, WI	7/1 - 8/15/86	Dependence in self care.
SP	N/A			

F. Evaluations: (Indicate Dates/Tests Used/Results) (Provide Date of Initial Evaluation).

1) 5/18/87 Comprehensive Functional Evaluation upon admission to nursing home. ADL-dependence in all areas of self care. Motor Skills - see attached ROM, M.M.T., and Coordination Tests. Perceptual Skills - assessment attached.

2) 6/22/87 ADL - can perform oral, facial hygiene, dress upper extremity with physical assist. Motor Skills - Refer to attached chart with ROM, M.M.T., and Coordination.

3) 7/27/87 ADL - dress upper and lower extremities, but needs assistance with buttons and zippers. Homemaking Eval. - see attached. Motor Skills - refer to attached chart with ROM, M.M.T., and Coordination.

G. Describe progress in measurable/functional terms since treatment was initiated or last authorized:

1. Client is now able to button 1" buttons, but lacks finger dexterity to accomplish smaller sizes.

2. Client can perform all other areas of personal care including dressing, hygiene, toileting, bathing.

3. Range of motion has improved significantly in most areas - see attached charts 5/18; 6/22; and 7/27/87.

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H. Plan of Care (Indicate specific measurable goals and procedures to meet those goals).

1. Client will manage 1/2" and 3/4" buttons and zippers.

2. Client will increase and maintain ROM to functional limits for his disability. A home program of exercises will also be initiated.

3. Client will prepare all meals independently with adaptations. Laundry and light cleaning skills will also be initiated.

I. Rehabilitation Potential:

Expect discharge to adapted apartment by December 15, 1987.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J. S M. Prescribing
Signature of Prescribing Physician
(A copy of the Physician's order sheet is acceptable)

MM/DD/YY
Date

S M. Performing
Signature of Therapist Providing Treatment

MM/DD/YY
Date